Towards a New Paradigm for Research on Urban Women’s Health

Toba Bryant
Centre for Research on Inner City Health, St. Michael’s Hospital, Toronto

KEYWORDS: WOMEN’S HEALTH, SOCIAL DETERMINANTS OF HEALTH, URBAN HEALTH, POLITICAL ECONOMY

This paper considers the literature on the determinants of urban women’s health through a political economy perspective. This approach is concerned with how society organizes and distributes social and economic resources. These distributions of resources lead to qualitatively different environments that affect women’s health. While there is increasing concern about the quality of urban environments in Canada and their impact on the health of Canadians in general, and women in particular, there is little consideration of how urban environments—especially the social determinants of health— influence women’s health. Instead, a review of the women’s urban health research literature reveals a primary focus on the incidence and prevalence of a variety of disorders among women and issues of access to services and treatment. When urban environments are considered, inquiry is limited to identifying the locations in which women with a variety of afflictions are found. Studies rarely consider the political, economic, and social forces that create these disadvantaged environments, nor how these environments lead to poor health. This paper draws on the emerging social determinants of health literature to present new directions for women’s urban health research.

In this article, I provide a paradigm for improving our understanding of urban environments and how they influence the health of Canadian women. Rather than considering the usual characteristics of urban environments such as built or physical spaces and the presence of toxic substances, I focus on aspects of the environment that pertain to the social determinants of health.

My main argument is that the health of women in urban centres is strongly determined by the quality of a variety of social determinants of health —income, housing, employment— that are themselves influenced by the organization of societies and how these societies distribute material resources among their members.

The focus on the politics and economics of distribution is a key component of what is termed a political economy approach to understanding health.

1 The research upon which this paper is based was funded by a research grant from the National Network on Environments and Women’s Health. The views expressed in this paper are not necessarily those of the Network. Address all correspondence to Toba Bryant, 62 First Avenue, Toronto, ON, Canada, M4M 1W8 (email: toba.bryant@sympatico.ca).
After reviewing existing definitions of urban health, urban environments, and social determinants of health, I summarize the predominant themes present in existing research on the health of urban women. I conclude that many of the important determinants of women’s health—related to their exposures to environments of varying quality—do not receive the research attention they deserve. To remedy these gaps I propose an urban women’s health research agenda that focuses on a) the social determinants of health, b) applies a gendered analysis, c) considers women’s lived experiences of these social determinants, and d) identifies the public policies that underpin the quality of these urban environments.

Urban Environments & Women’s Health

Eighty percent of Canadian women live in Canada’s urban areas (Government of Canada, 2004). It is important therefore, to understand how urban environments influence women’s health and to identify means of improving both these environments and the health of women living in them. While an emerging literature examines the relationship between promoting health and the built environment—usually concerned with physical and spatial aspects and presence of toxic substances—there is a more health-relevant aspect of environments concerned with the social determinants of health.

‘Social determinants of health’ are the economic and social factors that determine health (Raphael, 2004). The quality of these reflects how a society chooses to distribute resources among the population (Bryant, 2006). Such a focus is the hallmark of a political economy approach to understanding health, an approach that is receiving increasing emphasis (Armstrong, Armstrong & Coburn, 2001; Raphael, Bryant & Rioux, 2006).

These societal factors that affect health go by various titles such as prerequisites for health, determinants of health and social determinants of health, among others (Health Canada, 1998; Wilkinson & Marmot, 2003; World Health Organization, 1986). A Canadian synthesis of these factors identifies 11. The most important factors appear to be income, housing and food security, availability of health and social services, employment security and working conditions (Raphael, 2004). Much evidence suggests that the quality of the social determinants of health to which many Canadian women in urban areas are exposed is of problematic quality (Armstrong, Lippman & Sky, 1997; Donner, 2002). Interestingly, much of the attention to the quality of the social determinants of health and their potential impact on women’s health comes not from the health sector, but from non-governmental organizations concerned with urban sustainability, quality of life and family well-being (Campaign 2000 (2002; 2004); Federation of Canadian Municipalities, 2004; United Way of

In this paper, urban environments refer to the quality and availability to women in urban areas of societal resources such as income, housing, health and social services, educational and recreational opportunities and employment. I consider how macro-level political, economic and social policies influence the quality of these environments. I do not consider the built environment, although the built environment also reflects these political, social and economic policies (MacIntyre, Ellaway & Cummins, 2002; Northridge, Sclar & Biswas, 2003).

Political economy is concerned with the organization of society and how it distributes social and economic resources (Armstrong & Coburn, 2001; Coburn, 2006). This perspective directs attention to the relationship between health and the economic, political and social lives of different people, geographic areas or societies. Political economy is also a materialistic approach because it perceives ideas and institutions as arising from the way in which a society organizes production and considers the distribution of resources. It recognizes politics and economy as fundamentally related (Armstrong & Coburn, 2001). It is also concerned with how such attributes as gender, class and race/ethnicity structure participation and outcomes (Armstrong, 2004).

Political economy also takes into account how political ideology influences how a society functions, in particular, in its distribution of economic and social resources to its members (Bryant, 2006). Of recent interest in the literature is the role of neo-liberalism which advocates free enterprise as the means to foster economic growth and as the basis for all human well-being (Coburn, 2001; Coburn, 2004). Within the context of women’s urban health, the focus is on how society distributes resources and locates gender within the social hierarchy and how social and economic environments in which women live affect their health. Political economy is consistent with a focus on the social determinants of health that are concerned with social and economic environments and the distribution of social and economic resources within a society.

**What is Urban?**

Urban is about living in cities. Statistics Canada defines ‘Urban Canada’ as Census Metropolitan Areas (CMAs) whose urban core and adjacent urban and rural areas have populations greater than 100,000 (Statistics Canada, 2004). These CMAs include all neighbouring municipalities where 50% or more of the workforce commute into the urban core. Canadian urban environments are usually characterized by the availability of a range of cultural activities, health and social services
and other amenities.

An important assumption about cities drawn from urban sociology is that place matters (Fitzpatrick & LaGory, 2003). In this context, urban areas are platforms for exposures to risks that result in differential physical and mental health outcomes among the population. In my analysis of the social determinants of women’s health, I consider to what extent these risks are distributed differently amongst women as a function of income, race and immigrant status. In urban areas, economic and social residential segregation have implications for health. Social exclusion, a social determinant of health that encapsulates many health determinants, considers such processes (Galabuzi, 2004; 2005).

What is Urban Health?

The traditional urban health approach: The urban health field has a medically-oriented focus on incidence of illness characterized by the application of epidemiological methods. This research draws attention to patterns of disease and illness in urban areas and issues of access to health and social services. The dominant research paradigm is usually that of the ‘objective’ scientist who uncovers these patterns and access barriers but leaves the uncovering of public policy implications of these findings to others. The programs of recent International Conferences on Inner City Health show these emphases (International Society on Urban Health, 2002; 2003; 2004).

Public health approach: A Montreal based urban health report outlines four key dimensions that inform discussion of urban health and its determinants: the natural and built environment, the political and social environment, health infrastructure and social and community infrastructure (Lessard et al., 2002). Key population characteristics are its cosmopolitan and mobile nature, the complexity of its social networks and anonymity and the presence of social inequalities. Key urban health issues are adaptation and social integration, chronic diseases, accidental injuries and locomotive problems and communicable diseases. The Montreal health unit’s approach is unique as most public health activities in Canada focus on individual risk assessment (e.g., diet, physical activity, substance abuse, etc.) rather than environments and related concepts.

Healthy cities approach: This policy-oriented approach to urban health originated in Canada but saw its fruition in Europe. Healthy cities act to provide clean, safe physical environments of high quality (including housing quality), stable and sustainable ecosystems, supportive and non-exploitative communities, community participation and control over decisions that affect people’s lives, health and well-being, meeting basic needs and access to various experiences and resources (World Health
Cities in the network are expected to act to reach these goals.

Projects have six aspects concerned with the environments: a focus on health rather than illness, political decision-making that addresses housing, education, social service and other programs, intersectoral action, community participation and innovation to achieve healthy public policy. The Belfast Declaration, the most recent thinking on the approach, calls for a) collaborative efforts for good urban governance, b) designing environments to meet citizens’ needs, c) tackling wider determinants of health and d) effective policies and strategies for action (World Health Organization, 2003).

Other Canadian approaches: I briefly mention two urban health-related conceptualizations from non-health sectors. The Federation of Canadian Municipalities’s (2001) quality of life indicators clearly have health implications. These track population characteristics and growth, cultural diversity, household income and other variables in relation to ten domains: affordable housing, civic engagement, community and social infrastructure, education, employment, local economy, natural environment, personal and community health, personal financial security and personal safety.

The Canadian Policy Research Network’s (CPRN) quality of life project identifies 10 quality of life themes (Michalski, 2001). These are—in order of perceived importance by Canadians—political rights and values, health including health-care, education, environment, social programs, personal well-being, community, economy and employment and government. I carried out a review of the recent published research to determine to what extent these broader concerns are found in urban health research concerned with women.

**METHODOLOGY & GUIDING CONCEPTS**

I collected studies from academic journals, research institutes, funding agencies and women’s community service organizations. Disciplines examined were community health, economics, medicine, nursing, political science, population and public health, psychology, social policy, social work and sociology. Databases searched were Cumulative Index to Nursing and Allied Health, Proquest Nursing Journals, Medline, Evidence Based Medicine Reviews such as Cochrane DSR, ACP Journal Club, DARE, World Health Organization, PsycINFO, Sociological Abstracts, Web of Science, Ethnic NewsWatch, Studies on Women and Gender Abstracts.

I examined 135 health-related studies on women from 2003-2004
identified by using the search terms “women and urban and health” supplemented by searches on women or female or gender, Aboriginal, francophone, Québécois, colour or minority, violence, abuse, homelessness, housing and income. Few studies on Francophone women were identified, probably because only English-language research was examined.

Studies applied at least one indicator to explain the health status of individuals, groups, or populations of women. Outcomes included actual indicators of health such as self-rated health, morbidity or mortality, or health determinants such as income, housing, employment, abuse, violence and access to health and social services. The review and analysis was guided by specific concepts of urban health and gender—defined below—and by the questions in Table I.

**Table I. Questions Considered in the Review of Women’s Urban Health Research**

1. How do researchers conceptualize environments as influencing health?
2. What is the justification for including a particular environment in the study?
3. What structures mediate the environment and health relationship?
4. How is the environment or its proxies measured?
5. How is health measured?
6. Who or what phenomena are being studied?
7. What pathways are presented to explain the environment and health relationship?
8. What is the methodology used to study the environment and health relationship?
9. What types of policy implications do the researchers present?

*Urban health:* Improving health is complicated by the existence of competing paradigms for understanding health and its determinants. Health can be understood in strictly biomedical terms, as resulting from behavioural risks, or showing the impacts of how society organizes and distributes resources (Labonte, 1993). Consistent with a political economy perspective, I believe that structural issues such as how income, employment and housing opportunities are distributed among the population are the primary determinants of health of Canadian women in urban areas (Raphael, 2004).

*Gender & urban health.* One important consideration is the primacy of gender and gender relations in almost all aspects of urban form and urban life (Ray & Rose, 2000). Gender interacts with other social relationships,
including ethnicity, race and racism, sexuality and class to affect the quality of various social determinants of health to influence health. Issues of power are embedded in these relationships and should be explicitly identified. Gender also affects the participation in and consequences of health care, the opportunities to have good health and the experience of health and its determinants by men and women (Armstrong, 2004).

Since many gender issues are fundamentally about power relations between women and men, gender analysis considers how gender roles and gender-inequitable power relations influence the attainment of gender equality and equity, among other public policy goals and objectives (Commonwealth Secretariat & Maritime Centre of Excellence for Women’s Health, 2002). These concepts are critical to understanding women’s health and move us well beyond rather limited biomedical understandings of incidence, prevalence, morbidity and mortality issues to consider the critical role environments play in influencing women’s health.

**FINDINGS FROM THE LITERATURE REVIEW**

Much of the empirical literature reviewed defines women’s health in biomedical and epidemiological terms of incidence, risk and prevalence of particular diseases such as breast cancer and other cancers, diabetes and coronary heart disease. The primary methodological approach is cross-sectional surveys. Table II lists the themes dominate this literature.

**Table II: Dominant Themes in Women’s Urban Health Literature**

<table>
<thead>
<tr>
<th>Theme</th>
<th># of Studies</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>Obesity/weight issues</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Venereal Disease/reproductive issues</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Violence Against Women and Woman Abuse</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Mental Health</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Access to Social and Health Care</td>
<td>41</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td></td>
</tr>
</tbody>
</table>
There are more studies on access to care than on any other single theme. This may be attributed to the large number of American studies that are concerned with access to care for individuals and families without health insurance coverage. There is clearly a predominant research emphasis on issues of HIV/AIDS and venereal disease.

**HIV/AIDS incidence, prevalence, risk factors, co-morbidity, attitudes, treatment & outcome:** Studies focus on particular aspects of HIV/AIDS infection, such as susceptibility, understandability of, or treatment related to its presence (Andersen et al., 2003; Gregson, Terceira, Mushati, Nyamukapa & Campbell, 2004; Arend, 2003; DeMarco & Johnsen, 2003; Dixon, Peters & Saul, 2003; Herndon et al., 2003; Hilderbrand, Goemaere & Coetzee, 2003; Jones, Beach, Forehand & Foster, 2003; Kenagy et al., 2003; Klein, Elifson & Sterk, 2003; Kleinschmidt, Maggwa, Smit, Bekinska & Rees, 2003; Massad et al., 2004; Matsika-Claquin et al., 2004; McCalman, 2003; McDonnell, Gielen & O’Campo, 2003; Mellins et al., 2003; Norr et al., 2003; Parikh, Cheng, Nieman & Grimes, 2003; Peterson, Han & Freund, 2003; Remennick, 2003; Shefer & Smith, 2004; Silver et al., 2003; Shrotri et al., 2003; Simoni, Sehgal & Walters, 2004; Steven et al., 2004; Stringer et al., 2004; Theall et al., 2003; Wechsberg et al., 2003; Williams et al., 2003; Wu et al., 2003).

**Obesity/weight issues:** Many studies examine factors leading to weight gain and obesity among women. Most focus on low-income populations and some are in developing nations (Adebamowo et al., 2003a/b; Afolabi Addo, & Sonibare, 2004; Evenson et al., 2003; Eyler et al., 2003; Florencio et al., 2004; Galobardes et al., 2003; Horvat, 2003; Kreuter et al., 2003; Santiago & Coyle, 2004; Sujatha et al., 2003; Thompson et al., 2003; Wen et al., 2003).

**Venereal disease/reproductive issues:** Many studies focus on the incidence of and risk factors for venereal diseases. These include studies of women’s risk behaviours and attitudes associated with unprotected sex and how these relate to risk of venereal disease contraction. Many focus on low-income or other marginalized women (Bachmann et al., 2003; Behets et al., 2003; Berkowitz et al., 2003; Choi et al., 2003; Crandall et al., 2003; de Sanjose et al., 2003; Dixon, Peters, & Saul, 2003; Euler et al., 2003; Fenton, Whitty, & Reynolds, 2003; Forss et al., 2004; Hilderbrand, Goemaere, & Coetzee, 2003; Johnston, Boyd, & MacIsaac, 2004; Klima, 2003; LaVallie et al., 2003; Jones, 2004; Klein, Elifson, & Sterk, 2003; Lichtenstein et al., 2004; Kleinschmidt et al., 2003; Massad et al., 2004; Semaan et al., 2003; Vonderheid, Montgomery & Norr, 2003).

**Violence against women:** Most of these studies focus on the incidence and prevalence of domestic violence and the presence of co-morbidities such as physical (e.g., HIV, substance abuse, etc.) and mental illness (e.g.,
depression, suicide, etc., Cox et al., 2004; De Welde, 2003; Dienemann et al., 2003; Dugan, Nagin, & Rosenfeld, 2003; El-Bassel et al., 2003; Euler et al., 2003; Kramer, Lorenzon, & Mueller, 2004; Maziak & Asfar, 2003; McFarlane et al., 2004; Petersen et al., 2003; Rossman et al., 2004; Swahnberg et al., 2004; Wu et al., 2003).

Mental health: Studies usually focus on the mental health and well-being of disadvantaged populations including those with co-morbidities such as HIV/AIDS or cancer. They examine access to appropriate care. Another focus is risk factors for mental illness (Doi & Minowa, 2003; Fuhrer, Dufouil & Dartigues, 2003; Heilemann et al., 2004; Jones et al., 2003; Lehtinen et al., 2003; Mellins et al., 2003; Morris-Rush, Freda & Bernstein, 2003; Noorbala et al., 2004; O’Malley, Forrest & Miranda, 2003; Reviere et al., 2003; Rosen et al., 2003; Templeton et al., 2003).

Access to social safety & health care: These studies consider access to screening and preventive care and treatment for physical and mental illness of marginalized populations such as the poor. Studies on screening issues are increasingly common in developing nations and access to social assistance is a research focus in American studies (Adamson et al., 2003; Allard, Rosen, & Tolman, 2003; Andersen et al., 2003; Bentley & Griffiths, 2003; Bourjolly, Hirschman & Zieber, 2004; Brady et al., 2003; Buor, 2004; Chacko et al., 2003; Charlton, 2003; Comino & Harris, 2003; Coory, 2003; Coughlin et al., 2003; Couto, 2003; Dalton et al., 2003; DeMarco & Johnsen, 2003; Ehrlich et al., 2004; Fernandez-Esquer et al., 2003; Garbers et al., 2003; Gorey et al., 2003; Gregson et al., 2004; Herndon et al., 2003; Jibaja-Weiss et al., 2003; Johnson et al., 2003; Jongudomkarn & West, 2004; Juon, Seung-Lee & Klassen, 2003; Kenagy et al., 2003; Kiger, 2003; Kusuma, Babu & Naidu, 2004; Landim & Nations, 2003; Levy-Storms & Wallace, 2003; Lukwago et al., 2003; McFarland, 2003; Oluwole et al., 2003; O’Malley, Forrest & Miranda, 2003; Schootman, Kinman & Farria, 2003; Sorensen et al., 2003; Spitzer et al., 2003; Sullivan et al., 2003; Swigart & Kolb, 2004; Van Hook, 2003; van Olphen et al., 2003; Young, 2003).

ILLUSTRATIVE STUDIES FROM WOMEN’S HEALTH LITERATURE

HIV/AIDS: A biomedical and epidemiological focus is common in HIV/AIDS research. Although the demographic characteristics of samples are provided, few studies consider how these issues inform understanding of the incidence and prevalence of HIV/AIDS among particular populations. Study samples tend to consist of low-income women of diverse ethno-cultural backgrounds living in American inner cities. These women are seen as at risk for HIV/AIDS, hepatitis B and C viruses, particularly if they are intravenous/injection drug users (Evans
et al., 2003; McDonnell, Gielen & O’Campo, 2003). Some studies examine risk perception among this subpopulation (Evans et al., 2003; Klein et al., 2003; Theall et al., 2003). Few studies consider how the social and economic or urban context in which research participants live affect their risk of contracting HIV/AIDS or other diseases associated with injection drug use or other risk behaviours.

Epidemiological studies on HIV/AIDS and women consider the prevalence and predictors of HIV testing and treatment (Dixon et al., 2003; Mellins et al., 2003; Smith et al., 2003; Tucker et al., 2003). The predominant methodology of these studies is cross-sectional surveys and structured interviews. The studies confirm high rates of HIV testing among impoverished women. Women living in shelters do not experience barriers to HIV testing, but have difficulty accessing treatment (Bartley, Blane & Davey Smith, 1998).

Abuse & violence against women: Many studies address the incidence and prevalence of domestic violence (Cox et al., 2004; Miller, Azrael & Hemenway, 2002). However, little information is available on the incidence and prevalence of woman abuse and violence against homeless women, Aboriginal women, immigrant women and other groups of women in Canada.

Some research suggests woman abuse among low-income women as strongly related to poverty and as a public health issue (DeKeseredy & Schwartz, 2002; Renzetti & Maier, 2002; Williams & Mickelson, 2004). DeKeseredy and Schwartz (2002) argue that economic exclusion and patriarchal male peer support reinforce and justify male violence against women. These foci reflect a political economy orientation to understanding woman abuse in a specific social and economic context but further research into women’s health and violence is warranted.

Access to social safety & health care: Often using cross-sectional surveys, these studies address the access of marginalized populations of women to primary health care and income support such as social assistance. Of 11 studies identified, three examined access of marginalized (Aboriginal or homeless) women in Canada or the USA to health and social services (Allard, Rosen & Tolman, 2003; Benoit, Carroll & Chaudhry, 2003; Crandall et al., 2003; Heslin, Andersen & Gelberg, 2003). Some studies examined the health service needs of homeless women in large American cities (Allard, Rosen & Tolman, 2003; Andersen et al., 2003; Bourjolly et al., 2004; Lewis, Andersen & Gelberg, 2003). Other studies consider incidence of mental health diagnoses among low-income city women (O’Malley et al., 2003; Reviere et al., 2003; Rosen et al., 2003) and how these are associated with screening programs for urban women (Oluwole et al., 2003; Peterson et al., 2003).
Access to treatment and screening for diseases is important. However, the close scrutiny by health professionals of health problems—especially those associated with stigma such as HIV/AIDS—can be used to justify intrusions into other areas of women’s lives and possibly lead to further stigmatization. Such stigma can reinforce social exclusion and result in denial of services. Moreover, a focus on screening and medical interventions can preclude examining structural causes of illness, such as public policies on risk and morbidity. Future research should identify less intrusive strategies to identify the health needs of this population within an understanding of the structures that influence risk.

Virtually all of these studies are traditional epidemiological survey studies. Qualitative research could provide insights into the lived experiences of inner city women with HIV/AIDS and other problems and how they understand their risk of exposure (Loppie & Gahagan, 2001). Few studies have attempted this. Research on material or social-economic conditions on the incidence of HIV/AIDS and other diseases among women could enhance understanding of these health issues. The considerable evidence on the importance of material factors to increased risk of disease, disability and death (Walters, 2003) underscores the need for research on the influence of structural aspects of society on the incidence of disease and the experience of living with it.

Where do Environments—or Social Determinants of Health—Fit in This Literature?

Most studies do not explicitly examine the political, economic and social forces that increase the risk of certain populations of women to particular diseases. The exceptions are notable (see Galobardes et al., 2003; Gerhardt et al., 2003; Kushel et al., 2003; Macintyre et al., 2003; Mapalad-Ruane & Rodriguez, 2003; McDonnell et al., 2003; Pomeroy & Jacob, 2004) in that they consider either how urban environments influence women’s health, the social causes of disease, or the broader influence of macro-socioeconomic policies on urban environments and women’s health. The series of questions summarized in Table I will now be readdressed.

How Do Researchers Conceptualize Environments As Influencing Health?

Environments can be seen as providing exposure to social determinants of health are either health enhancing or health threatening. Three main frameworks can inform how these effects develop (see Raphael, 2004 and 2005 for more details).

The materialist analysis on how social determinants influence health looks
at how individuals of differing groups are exposed to varying degrees of positive and negative exposures to risk factors or conditions over their lifetime. These exposures are seen to accumulate to produce positive or negative health outcomes. “[T]he social structure is characterized by a finely graded scale of advantage and disadvantage, with individuals differing in terms of the length and level of their exposure to a particular factor and in terms of the number of factors to which they are exposed” (Shaw et al., 1999, p. 102). The link with health of indicators as income, wealth, educational attainment and occupation show how material advantage accumulates over the lifespan. Materialism is consistent with a political economy approach with its focus on the influence of social, economic and political structures on health and how public policies can address these.

Also consistent with political economy, the neo-materialist approach argues that jurisdictions differ in both the distribution of resources among the population and their investment in public infrastructure. “[T]he effect... on health reflects a combination of negative exposures [to risk-factors/conditions] and lack of resources held by individuals, along with systematic under-investment across a wide range of human, physical, health, and social infrastructure” (Lynch et al., 2002, p. 1202). Neo-materialist analysis considers how public expenditures on health and social services, social welfare and supports for marginalized groups, the unemployed and those with chronic conditions or disabilities influence health.

The social comparison approach sees health as related to citizens' interpretations of their standing in the social hierarchy. These perceptions lead to health-threatening stress and adoption of health-threatening coping behaviours such as overeating and substance use. At the communal-level, widening of hierarchies cause distrust and suspicion of others. This approach considers how marginalization and exclusion threaten the health of particular groups of urban women.

The literature rarely considers environments as causative agents in women’s health. Most studies simply identify environments as the physical locations where women with particular pathologies are likely to be found. These identify women who could benefit from medical treatments or health promotion interventions. Few studies explain how environments provide specific exposures that affect the health of the women in their samples by increasing their risk of disease or providing benefits from receipt of health care and social service interventions.
What Is The Justification For Including A Particular Environment In The Study?

Few studies explain why a particular environment is chosen. Often, outside of the chosen environment remains as merely a descriptor. For example, the HIV/AIDS studies identified urban environments as having high incidences of HIV/AIDS, but few explained why this is the case, or why low-income women in urban areas have high risk and show the highest incidences of HIV/AIDS. Studies could consider how federal and provincial housing and income policies, or policies on health and social service provision may exacerbate the poor material conditions of these women, and contribute to their poor health status.

What Structures Mediate, the Environment & Health Relationship?

Environments consist of horizontal and vertical structures. Horizontal structures are the more immediate aspects of environments such as community characteristics, employment conditions, housing and food insecurity and how they influence health. Vertical structures are macro economic, labour and social policies and their influence on resource allocation and income distribution. These could consider the impact of political ideology, policies on unionization and union density and other structural issues on women’s health. Virtually none of these issues were discussed in the studies I reviewed.

How Is The Environment or Its Proxies Measured?

Few studies assess the nature and quality of environments. As stated, urban environments are usually the background for phenomena under investigation. Few consider the effects of inner cities as platforms for unequal distribution of risk among residents, and how such environments interact with gender and other social dimensions.

How Is Health Measured?

Primary consideration is the incidence and prevalence of disease categories or experiences such as abuse. Few studies consider the quality of the environments (i.e., the social determinants of health) in which urban women live and how these affect their health.

Who or What Phenomena Are Being Studied?

Women studied are usually low-income with an affliction and residing in impoverished urban areas. Little work considers the health of women in general. When such work is done (see the Women's Health Surveillance Report, 2003) the focus is the incidence of various disorders with the association of socioeconomic status but little analysis of why this
association may be present (Gatali & Archibald, 2003; Grace et al., 2003; Kasman & Badley, 2003; Walters, 2003).

What Pathways are Presented To Explain The Environment & Health Relationship?

Raphael and colleagues identify numerous pathways that can mediate the environment and health relationship (Raphael et al., 2003):

- Biological make-up of the individual, e.g., genetics, physiological processes, individual characteristics such as age, gender and family history
- Materialist, impact of elements of the individual’s environment, e.g., work hazards, housing quality, exposure to pollutants, impact of unemployment or employment status on ability to purchase goods
- Social class, social class/group, ethnicity, educational attainment and occupational group
- Psychosocial stress, stress, depression, anxiety, leading to disease or health outcomes
- Psychosocial comparison, emotional response caused by individual comparison and experience of relative deprivation
- Behavioural/risk-factors, smoking, drinking, exercise and general lifestyle
- Gender analysis, a description of why or how an individual’s gender influences their health status—usually but not always oriented to females
- Political-economic analysis, based on the view that societal structures (e.g., neo-liberalism, global economy, racism, welfare state decline, sexism, lack of access to education) create inequalities.

My analysis reveals that among the studies reviewed, pathways considered are limited to biological, social class and behavioural/risk factors. There is little analysis of the material conditions of women’s lives or political-economic issues. A few studies provide gender analysis on particular issues associated with women’s health, usually for health planning purposes.

What Is the Methodology Used To Study The Environment & Health Relationship?

The research is quantitative, usually cross-sectional, with an epidemiological orientation. A developed determinants of health approach would define women’s health in terms of urban or rural
environments, material conditions such as housing, income and its
distribution, food security, opportunities, education and recreation that
influence women’s health and well-being.
Women’s constructions and understanding of health are rarely studied
(for some exceptions see Hofman, 2003; Holt et al., 2003; Saewyc, 2003;
Weissman et al., 2004). Consistent with political economy, a critical
inquiry should link these constructions with the material conditions of
women’s lives (Obrist, 2003). Broader definitions of health incorporate
lived experience and the primacy of material conditions in women’s lives
and consider how public policies affect women’s health.

Health research should also consider the primacy of gender and the
connections between gender and health (Walters, 2003). This highlights
gender issues in policy making and change and requires gender analysis
to compare women’s and men’s health and how gender structures
opportunities across the lifecycle.

What Types Of Policy Implications Do Researchers Present?
A range of policy recommendations is possible (Raphael et al., 2005):
• Political and economic structural systems, globalization, political
  and economic governmental policies (e.g., welfare, taxation,
  general redistribution of wealth, work programs)
• Social determinants of health, education, employment, inclusion,
  child and parent issues, food security, housing, access to services
  and racial and ethnic issues
• Health care services, medical model approaches to health care
  practices and policies (e.g., physician behaviour and skills) and
  access to services
• Lifestyle (individual-level), health promotion initiatives and
  prevention strategies aimed at healthy lifestyles (i.e., restricting
  smoking in public buildings, education about diet).

When studies recommend policies, they focus on health care services
and lifestyle but rarely focus on income, housing and other policies as
social determinants. While there is some recognition of the importance of
social determinants of health, such action is usually seen as secondary to
the other policy areas.

Filling the Gaps & Moving Forward on a Women’s Urban Health Research
Agenda
My review illustrates how research on urban environments and
women’s health could be enhanced. The particular areas of weakness are
conceptualization of both environments and how these environments
contribute to women’s health. Little inter-disciplinary work examines the political and economic forces that influence how environments differ among groups of women. Even fewer identify pathways by which environments influence women’s health. These issues need to be examined within a framework that considers how they interact with gender issues to influence health over the lifespan. Income, employment opportunities and health and social services are important as they provide basic needs and enable activities expected in a society.

I suggest four components of urban women’s health agenda: a) emphasis on the social determinants of health, b) a gendered analysis, c) the lived experiences of women and d) analysis and advocacy for public policy that supports health.

The social determinants of health: Health research on women has neglected the role of the social determinants of health (exceptions are Amaratunga, 2000; Armstrong & Armstrong, 2002; Colman, 2000; Kosny, 1999). This is especially problematic as there are indications that the quality of any number of social determinants of health is worse for Canadian women than for Canadian men (Tremblay, 2004). This is the case for income, housing, employment security and working conditions (Jackson, 2004). Moreover, the situation of women with disabilities, racial group or immigrant status is especially problematic (Clark, 1998; Galabuzi, 2001; 2004; Raina et al., 2000).

The situation in most Canadian cities shows growing income inequality, poverty and economic segregation of neighbourhoods. These issues are of special importance to women, as poverty is increasingly a women’s issue. Infant mortality, ischemic heart disease, uterine and lung cancers, diabetes and suicide rates among women show a gradient related to income quintiles. The gradient is especially high for suicides where women in the lowest income quintile have 2.5 times greater rates than women in the most advantaged areas (Wilkins et al., 2002).

Canadian women have a higher incidence of low income than men. The data on female lone-parent families show strikingly high rates of low income. Income differences eventually affect health through processes of material and social deprivation across the lifespan. Insufficient spending on social infrastructure exacerbates these effects. Women, due to their greater economic vulnerability, are especially susceptible to the effects of regressive public policy decisions.

Closely related to income is housing problems. Income determines the quality of housing. Recent data show that income support programs on which many women rely have not kept pace with the cost of rental housing in major Canadian cities (Federation of Canadian Municipalities, 2004). The withdrawal of the federal and some provincial governments
from housing and rent deregulation has increased the vulnerability of low-income women and their children. Female-led households constitute 45% of Canadian households with a core housing need (Rude & Thompson, 2001).

The Women's Health Surveillance Report (2003) shows how social determinants of health are relevant to women’s health. The incidences of cardiovascular disease, arthritis and HIV/AIDS are strongly related to income status and other indicators of exclusion such as minority status and education (Gatali & Archibald, 2003; Wingood, 2003; Tucker et al., 2003).

**Gender analysis:** Gender analysis is an essential component of any approach to women’s urban health. The research I reviewed, while focused on women, did not place women’s environments and their effects in the context of differential experiences of men and women (Donner, 2003). Gender analysis can be applied in the traditional ways, for example, how gender leads to differential outcomes and how differences between men and women in health status, health care utilization and why women and men face different health issues as a result of differential exercise of power. It makes explicit how gender roles and gender-inequitable power relations can influence policy change to reduce gender inequality (Donner, 2003). A more advanced gendered analysis must consider the political, economic and social forces that lead to women’s experience of profoundly different environments as a result of their gender, class and race. The latter type of analysis must consider why gender issues persist despite the recognition of some these issues by governments, policy institutes and women’s research and advocacy groups.

**Lived experiences of women:** A key criticism of traditional methodological approaches towards understanding community health is their inability to focus on the lived experiences of people (Bryman, 1988). In assessing need and identifying the roots of health, community members’ experiences involve complex patterns of interaction and situations that traditional approaches rarely address. Lincoln argues the most effective way to understand health-related issues is by discerning individuals’ perceptions and constructions of events (Lincoln, 1994).

Few studies consider women’s lived experiences (exceptions are Kubik & Moore, 2001; Nova Scotia Women’s FishNet, 2004). We know little about the lived experience of women in low-income conditions, or the meaning of poor housing and lack of resources in their lives. Examining lived experiences engages communities in research activity by giving them a voice in the public policy process. Such activities help to counteract the drive towards weakened democratic structures increasingly common in Canadian society.
Policy analysis & emphasis on change: New thinking on health and its determinants focus on how government decisions influence resource distribution. Governments differ on how they manage income, housing, employment and child development issues. These issues are important as urban environments are impacted by government policies. It is essential to understand the policy change process and identify strategies to influence policy outcomes (Bryant, 2001).

Public policy has been the domain of experts. In contrast, participatory policy analysis incorporates understanding of and advocacy by citizens. By linking expert knowledge with citizens’ practical knowledge to address policy issues (Fischer, 1993), participatory policy research fosters collaboration between scientists and citizens to address social welfare and democratic empowerment. It challenges the received paradigm by presenting knowledge based on citizens’ experiences and locating these experiences in scientific theory. This approach can guide research and advocacy activities on income, housing, social exclusion and urban health.

**IMPLICATIONS FOR WOMEN’S HEALTH RESEARCH AGENDA**

The most striking aspect of this research review on environments and women’s health is how little there is. Non-health sectors are more engaged in examining how environments are related to income, housing and employment status of women (see exceptions by Atlantic and B.C. Centres for Excellence in Women’s Health). The Canadian Centre for Policy Alternatives, Centre for Equality Rights in Accommodation and other non-governmental, non-health sectors have produced some of the most interesting work on women’s well-being.

A women’s urban health research agenda should be guided by a commitment to understanding through a political economy lens how political, economic and social environments influence women’s health through the social determinants of health. There should be a priority on how women understanding the determinants of health such as income, housing insecurity and lack of service access. Social determinants of health are important issues in urban health. What is lagging is research that employs these concepts in the study of urban women.
REFERENCES


Bryant: NEW PARADIGM ON WOMEN’S HEALTH


